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RELEASE FORM

NAME OF AUTHOR . .PATRICIA ANNE.GNIAZDOWSKY. . . . . .

TITLE OF THESIS . .COUNSELOR.PREFERENCES.OF THE HARD. . . .

. .OF HEARING . . . . . .

DEGREE FOR WHICH THESIS WAS PRESENTED MASTER.OF EDUCATION . .

YEAR THIS DEGREE GRANTED . .1977 . . . . . .

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THE UNIVERSITY OF ALBERTA

COUNSELOR PREFERENCES OF THE HARD OF HEARING

by

(C) PATRICIA ANNE GNIAZDOWSKY

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF MASTER OF EDUCATION

IN

COUNSELING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1977

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled .Counselor.Preferences.of the . .Hard of.Hearing. . . . . submitted by .Patricia Anne.Gniazdowsky. . . . . in partial fulfilment of the requirements for the degree of Masters of . .Education. . . . . .

ABSTRACT

The purpose of this study was to investigate the preference of hard of hearing individuals for hard of hearing counselors or hearing counselors. Five hypotheses were tested: (1) Hard of hearing individuals prefer a hard of hearing counselor to a hearing counselor; (2) Hard of hearing females show a greater preference for the hard of hearing counselor than hard of hearing males; (3) Hard of hearing individuals with hearing losses in both ears show a greater preference for the hard of hearing counselor than hard of hearing individuals with hearing losses in one ear; (4) The greater the degree of hearing loss, the greater the hard of hearing's preference for a hard of hearing counselor; (5) Hard of hearing individuals show greater preference for the hard of hearing counselor when the relationship involves discussing the handicap itself; i.e., problems with the self, home and social types of problems and less preference when the discussion involves problems relating to educational, vocational and moral matters.

The first hypothesis was supported at the .01 level of significance. The remaining four experimental hypotheses of this study were not supported. Other findings include: (1) Of the 31 respondents, 26 or 83.87 percent made incorrect estimations of their hearing loss, suggesting that misinformation, misunderstanding or lack of information prevails between the audiologist and the individual whose hearing is being evaluated; (2) The majority of subjects in this study were unfamiliar with any counseling services available to meet their needs; and (3) Eighteen respondents who stated a hard of hearing counselor preference, based

their choice on the commonality of problems between themselves and the counselor. The remaining 11 subjects chose the hearing counselor because they felt their hearing loss to be so slight that it would not interfere with the counseling situation or everyday living.

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to Dr. James Vargo for his guidance and helpful suggestions throughout the course of this thesis. Special thanks are also extended to Dr. George Fitzsimmons and Dr. John Paterson who served as the other members of my committee.

I would also like to express my sincere gratitude to Mrs. A. Lewchuk of the Audiology Department at the Glenrose Hospital, for her assistance during the initial organization of this project. Deep appreciation is also extended to all the subjects who participated in this study.

To my friends Darlene and Jackie, and my typist Lyn Ingram, my heartfelt thanks for their support and invaluable assistance.

Loving thanks to my parents, Mr. and Mrs. William Rawski, and to my grandparents, Mr. and Mrs. Peter Hospodarec for their continual support and encouragement.

Finally, I would like to dedicate this thesis to two very important individuals. To Dr. George Fitzsimmons for his genuine concern and encouragement in making my dream a reality, and to my son Andrew William, for the happiness he has brought into my life.

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CHAPTER I

INTRODUCTION TO THE STUDY

I. Introduction

With today's advancing technology and complexity in modern living, increasingly large demands are placed on society to adopt new techniques, change certain policies and seek future solutions to present problems.

Canada is known for its diversity and multitude of ethnic groups, each demanding a little for the development of its cause and the preservation of its ethnic identity. French-Canadians in Quebec, for example, have been fighting to maintain their unique sense of being. However, other groups seek recognition for reasons other than their ancestory origins. These groups may be characterized by the prominence of their handicap--for example, the deaf, the blind and the disabled. Moreover, as with certain ethnic groups, there is a multitude of handicapped individuals who have not yet attained prominent recognition, in terms of fulfilling their basic needs, in obtaining acceptance and understanding from society, and in expanding investigations to familiarize others with their particular handicap.

It is well known that the needs of the hard of hearing have been greatly neglected, if not ignored (Vernon & Billingslea, 1973; Berg & Fletcher, 1970). According to Vernon and Billingslea (1973), there are approximately one million hard of hearing school children in the United States who have special educational needs that are rarely met. The consequence of this neglect is that:

> . . . the overwhelming majority are significantly retarded academically, they are often misjudged to be of low intel-

> ligence, and frequently have serious behavior problems. Rarely do school systems adequately identify these youngsters or meet their needs, despite the fact that as a group they have a normally distributed learning potential. (Vernon & Billingslea, 1973, p. 28)

Therefore, it becomes necessary to establish special educational programs for the hard of hearing child. What these special educational programs are or should be, however, is still unclear. Nevertheless, to not accept this fact is to deny the hard of hearing child the right to attain his fullest potential.

Although this thesis focuses on adult hard of hearing individuals, it is necessary to review what counseling facilities are available to the hard of hearing child and adolescent, in order to see if there is a progressive development of counseling services for the hard of hearing.

The counselor plays an important function in counseling the hard of hearing. If the counseling process involves a young hard of hearing child, the counselor may find it feasible to include the child's parents in the counseling process. The purpose of total family involvement is to facilitate a more informative perception of the child's development and adjustment to his handicap by creating a mutual understanding about the limitations of a hearing handicap and possible alternative avenues available to the child.

Once the child finds himself within a school environment, the counselor and teacher play an influential role in helping the child to adjust to his new surroundings. However, if the child has a hearing impairment, his acceptance or rejection by the school personnel greatly influences how he performs within the school setting.

Murphy, Dickstein and Dripps (1960) and Conine (1968) suggest that

teachers do not accept disabled children and that hearing handicapped children tend to be considered less desirable to teach. In addition, Murphy, Dickstein and Dripps (1960) found that specialists (guidance personnel, nurses, special classroom teachers) indicated less acceptance of hearing handicapped children than other types of exceptional children (slow learners, emotional, visual, physically handicapped, gifted, speech and delinquent). However, the data also illustrated that ". . . the more a person feels he knows about a handicapping condition, the more inclined is he to want to work with children having that handicapped condition" (p. 210).

Therefore, a counselor knowledgable about the conditions of hearing impairment can be instrumental in educating teachers, students, parents and other school personnel about the handicapped child. Conversely, if a hard of hearing child enters school without his hearing loss detected, the counselor becomes an important agent in facilitating early recognition of a hearing disability.

The counselor should be sensitive to certain cues that may indicate the need for an audiological assessment. According to Blowers and Paterson (1976) some of the following cues may be evident:

> Poorly articulated speech, difficulty in learning phonetics, an inability to understand oral instructions, and teachers' complaints of poor motivation or general inattentiveness are common . . . . (p. 16)

Furthermore, Blowers and Paterson (1976) contend that:

> . . . when a hearing loss is suspected, the child should be given one or more audiometric assessments to establish thresholds of hearing; audiograms should be placed in the child's school health file, and medical intervention should be made where indicated. (p. 14)

However, it must be stressed that understanding audiogram reports is crucial if teachers and counselors are to help the hard of hearing child to adjust and to perform at a level consistent with his capabilities. Misunderstanding of the child's hearing and learning potential by the teacher and/or the counselor will result in the child not performing to his maximum potential (Cozard, Marston & Joseph, 1974).

In addition to the cues mentioned above, other indications of moderate to severe hearing loss are feelings of loneliness, isolation, fear, inadequacy, inferiority, negative self-worth, rejection, helplessness and hopelessness (Berg & Fletcher, 1970). According to Brooke-Hughes (1973):

> Many partially hearing young people experience acute feelings of isolation and loneliness because they feel excluded from the group--not the activities of the groups but the social interchange that occurs spontaneously. (p. 234)

The special needs of deaf adolescents for recreational and social contacts as well as vocational training and counseling seems to have gone largely unnoticed (Kane & Shafer, 1970). Therefore, it is essential that the counselor recognize the various problems encountered by hearing impaired youths and seek out or design programs to help deaf youths integrate with the community at large in order to reduce their sense of alienation and frustration that may carry into adulthood and contribute to the maladaptive attitudes many deaf adults develop. By redirecting hearing impaired youths to a more healthy and realistic outlook of themselves and their potentials, the counselor may alleviate unnecessary hardships that may be encountered.

Baker (1976) maintains that:

The school counselor must be prepared to help in the delivery

> of that special service just as he is prepared to help in the delivery of services for students within the normal range . . . . Counseling services for exceptional children and youth must be seen as an expansion of, and outgrowth from, counselor for the 'normal'. (p. 6)

Therefore, the school counselor must be knowledgable about all his students, the handicapped as well as the non-handicapped.

Although the basic principles of treatment, in terms of helping or therapeutic relationships remain much the same, the hearing disabilities may require some modifications within the counseling process. These modifications can only be made when the counselor understands the differences as well as the similarities that exist between the hearing impaired and the hearing clients. Wright (1970) outlines the counselor's responsibility in the following manner:

> The practitioner with hard of hearing clients must not only require the dynamics of behavior and personality development as required for indepth counseling, but he must also be more skilled than usual in transmitting genuine, emotional warmth and understanding by nonverbal as well as verbal means. In addition, he should, ideally have training and background for understanding the causes and nature of auditory disabilities and for working specifically with individuals so afflicted. (p. 163)

Whenever possible, the hard of hearing child and adolescent should be exposed to other hearing impaired individuals. Just like deaf children and adolescents need deaf models to communicate and associate with (Jacobs, 1974; Thompson, 1974; Bowe, 1973; MacDougall, 1971; Vernon, 1970; Vernon & Makowsky, 1969), hard of hearing children and adolescents need other hard of hearing models to emulate (Van Itallie, 1963). A hard of hearing child or adolescent should be given the opportunity of meeting and talking with other hard of hearing individuals, since they have traveled the same route and may understand each other in many ways.

It should not be concluded that all hard of hearing children and adolescents are underachieving educationally, maladjusted behaviorally, or undernourished experientially and socially--but those who are should be recognized by the teachers, parents, counselors and others in order that some solutions may be formulated to assist the hard of hearing child and later the hard of hearing adult to cope with his handicap and limitations (Knee, 1976).

In some instances, hearing loss in adults may have occurred during their later years. In this case, the problems encountered may not seem as serious, since self-concept is fairly well established. However, adjustments may be required in occupational, family and social situations. Again, the hard of hearing adult may have to recognize the realities of his handicap and learn to cope with the handicap and any limitations he may experience. A knowledgable and genuine counselor may help facilitate a healthy adjustment and a positive attitude toward the auditory disability.

Presently, it must be recognized that more information is required about the hearing impaired. Since there has never been a Canadian national census of the hearing impaired, it becomes difficult to construe what counseling facilities the hearing impaired are familiar with and whether or not there is a justifiable demand for counseling facilities for the hearing impaired.

A survey (Boesen, 1975) conducted by the Alberta Co-ordinating Council on Deafness looked into the needs of hearing impaired people in the Greater Edmonton region, in order to find out whether a Communication and Referral Centre might be established. It is evident from the

lack of research information and from the present survey that there is no place where the deaf and hard of hearing people can go, comparable to the Canadian National Institute for the Blind, whereby the blind can seek assistance and associate with others who are similarly afflicted.

From this survey (Boesen, 1975), it was found that deaf individuals were interested in seeing more interpreter and counseling services available to them. The hard of hearing sample listed counseling and information services as their highest priority. In addition, of the 46 deaf people surveyed, 26 percent did not know where to go for family counseling, 19 percent did not know where to seek marriage counseling, and 15 percent were uncertain about where to go for legal advice. Family and marriage counseling left 27 and 24 percent respectively of the 114 hard of hearing individuals interviewed at a loss as to where to seek assistance.

With this information, it is apparent that the counseling needs of the deaf and the hard of hearing have been greatly neglected. The hearing impaired in Canada should be provided with adequate counseling services to meet their needs and competent counselors to carry out these counseling services.

II. Purpose of the Study

The purpose of this study was to investigate whether hard of hearing individuals show a preference for hard of hearing counselors or for hearing counselors.

Specific Problems

The investigation sought to determine the preference of hard of

hearing individuals for hard of hearing counselors or hearing counselors, in terms of the following questions.

1. Do hard of hearing individuals prefer a hard of hearing counselor to a hearing counselor?

2. Do hard of hearing females show a greater preference for a hard of hearing counselor than do male hard of hearing individuals?

3. Do individuals with hearing losses in both ears show a greater preference for a hard of hearing counselor than do individuals with hearing losses in one ear?

4. Does the degree of hearing deficit have any relationship to the hard of hearing's preference for a hard of hearing counselor or a hearing counselor?

5. Do hard of hearing individuals show greater preference for the hard of hearing counselor when the relationship involves discussing the handicap itself; i.e., problems with the self, home and social types of problems.

III. Significance of the Study

Recently, increasing attention and research has been focused on the deaf, in terms of educational and vocational rehabilitation issues (Bolton, 1976; Sussman and Stewart, 1971; Mindel and Vernon, 1970). One of the main controversies is whether the oral or manual communication method should be enforced in the teaching practices of the deaf. This controversy reflects the negative result of the deaf segregating themselves from the normal hearing community, and setting up their own communities based on deaf individuals, deaf schools, insurance agencies

for the deaf and many other similar programs.

Hard of hearing individuals, by the very definition of their handicap, feel they do not belong to the hearing group (Wright, 1970; Griffith, 1974). The hard of hearing may be looked upon by the deaf as people who can hear; yet through the eyes of the hearing, they may be characterized as "not hearing well enough!" Therefore, it becomes necessary to recognize the hard of hearing as another subgroup within the hearing world.

One reason for the lack of research into the area of the hard of hearing may be disinterest on the part of the researcher due to the fact that the defect is less dramatic and apparent than deafness. Also, there is no conveniently centralized population as there is in a residential school for the deaf.

In addition, there is the problem of dealing with the various levels of hearing loss that exist within the hard of hearing realm. In order words, the term 'hard of hearing' entails more characteristics than does the term 'deaf'. Within the hard of hearing spectrum, there are four major hearing loss categories: slight, mild, moderate and severe. Therefore, when investigating partial hearing loss, the researcher must be specific about which type of hearing loss he is discussing.

It is inevitable that hard of hearing subjects present some unique problems beyond normal hearing clients. As mentioned earlier, there are additional requirements needed by a counselor for the hard of hearing.

In discussing counseling procedures with deaf individuals, Bolton (1976) maintains that:

> Deaf clients generally experience the same kinds of problems and difficulties that hearing clients do, although deafness does present some unique situations. Therefore, the basic nature of the counseling process is unchanged, but the mode of interaction is different. (p. 138)

Counseling with the hearing impaired must be conducted at the concrete level. Vernon (1967) comments that:

> Rogerians attempting to reflect affective overtones or responding with "hmmm's" which cannot be lip read (or heard) and for which there is no sign soon see their technique as inappropriate for the average deaf client. (p. 10)

This can also be applied to hard of hearing clients with severe hearing losses; they may not hear the counselor's responses to their statement of their problems. Therefore, counseling the hearing impaired must be improvised to accommodate the limitations faced by the hearing handicapped. Only when improvizations are made, can effective counseling be provided.

The counselor should also have some background in the etiology and nature of auditory disabilities (Sussman & Stewart, 1971). For Sussman and Stewart (1971) maintain that accurate knowledge about the causes of the hearing impairment will provide explanations for certain behavioral patterns that may occur as direct consequences of the hearing disability. As a result, Sussman and Stewart (1971) contend ". . . the counselor's evaluations of a client's potentials would be more exact, more relevant" (p. 132). Similarly, Purvis, Schein and Watson (1975) have found that ". . . even a brief exposure to the problems of deafness, coupled with the deaf person's potentials, will help the general counselor do a better job when he meets a deaf client" (p. 30).

Another alternative would be to refer hearing impaired individuals to a hard of hearing or deaf counselor who may be more qualified exper-

ientially, having faced some of the problems that their clients have encountered.

If a counselor is a hearing individual, an additional asset would be to learn to speak to the client directly, perhaps a little more slowly, using nonverbal gestures to provide reassurance and achieve rapport. Patience is another important attribute when counseling hard of hearing individuals, since they may require repeated explanations in order to understand what the counselor is attempting to communicate.

Perhaps the most important significance of this study is to illustrate the lack of information and research that exists in the area of counseling the hearing impaired, especially the hard of hearing. Another important function is to point out the need for qualified deaf and hard of hearing counselors within the counseling profession who have an understanding of the life problems and needs of hearing impaired people, and can communicate with the hearing handicapped. Vernon (1971) clarifies the need for hearing impaired counselors in the following manner:

> The concept of minority or disability groups being directly involved in their own rehabilitation at professional and decision-making levels is a valid one. Alcoholics Anonymous, Synanon, . . . and countless other successful programs have shown that minority group members usually have better insights, more commitment and greater rapport with their own than does the general population. (Sussman & Stewart, 1971, p. 38)

IV. Assumptions

It was assumed that the information obtained from respondents on the questionnaire was accurate and honest.

V. Definition of Terms

Hard of hearing implies specifically one kind of impairment; namely, a defective sense of hearing or simple loss of sensitivity presumably in the ear itself or in its nerve.

One ear hearing loss refers to a hard of hearing person who has sustained a defective sense of hearing in one ear only.

Two ears hearing loss refers to a hearing impairment in both ears; the loss may or may not differ in magnitude or degree.

Conductive hearing loss refers to an interference with the normal mechanical transmission of sound energy from the external ear into the inner ear.

Mixed hearing loss implies a combination of conductive with sensori-neural hearing loss, or a combination of middle ear with inner-ear hearing loss.

Sensori-neural hearing loss implies a hearing impairment due to abnormality of the sense organ, the auditory nerve, or both.

Normal hearing falls between 0 - 25 db.

Slight hearing loss ranges from 26 - 40 db.

Mild hearing loss ranges from 41 - 55 db.

Moderate hearing loss ranges between 56 - 70 db.

Severe hearing loss falls within the range of 71 - 90 db.

Profound hearing impairment refers to any hearing loss over 90 db. In this case, the sense of hearing is nonfunctional for ordinary levels of communication. Deaf individuals usually fall within this range.

Decibels (db) are a measure of loudness. The number of decibels

by which sound must be amplified from the faintest sound heard by the normal ear threshold to become perceptible to the hard of hearing individual is a measure of hearing loss.

VI. Hypotheses

1. Hard of hearing individuals prefer a hard of hearing counselor to a hearing counselor.

2. Hard of hearing females show a greater preference for the hard of hearing counselor than hard of hearing males.

3. Hard of hearing individuals with hearing losses in both ears show a greater preference for the hard of hearing counselor than hard of hearing individuals with hearing losses in one ear.

4. The greater the degree of hearing loss, the greater the hard of hearing's preference for a hard of hearing counselor.

5. Hard of hearing individuals show greater preference for the hard of hearing counselor when the relationship involves discussing the handicap itself; i.e., problems with the self, home and social types of problems and less preference when the discussion involves problems relating to educational, vocational and moral matters.

VII. Delimitations

This study was limited to hard of hearing subjects assessed by the Audiology Department at the Glenrose Hospital, in Edmonton, Alberta. Hard of hearing subjects assessed during the period of January to May 1977 were used in this study.

CHAPTER II

SOME RELATED LITERATURE

Very little literature has been published pertaining to the area of counseling the hard of hearing in general, or of the hard of hearing's preference for hard of hearing vs hearing counselors, in particular. Counseling the hard of hearing as well as counseling the deaf, has remained a relatively unexplored area. This is probably because there are only a small number of professionals in the counseling field for the hearing impaired (Williams, 1967; Vernon, 1967; Sussman and Stewart, 1971; Reddan, 1975), and because few practicing counselors have reported their experiences with deaf and hard of hearing individuals. It is the researcher's hope that the present study may generate some new information and motivate future research investigations in this area.

Literature related to preferences of hard of hearing individuals for hard of hearing or hearing counselors extends into four general areas: (a) general attitude toward the hearing impaired, (b) counselor's attitude toward handicapped individuals in general, (c) handicap's attitude and preference of counselors (normal and handicapped counselors) and, (d) the commonality concept.

General Attitude Toward the Hearing Impaired

Traditionally, a deaf individual was categorized as "deaf and dumb"--because he was incapable of speaking or reproducing sounds, he was considered to be lacking in intelligence as well. This type of evaluation coincides with Wright's (1960) conclusion that negative evaluations of the disability have a tendency of being generalized to

non-impaired characteristics of the person possessing the disability. In other words, the inability to hear has been erroneously equated with the inability to think.

Today, a deaf individual is characterized as deaf, but is recognized as "normal" in every other way. It has also been found that although deaf children and deaf adults score low on intelligence tests, this is not to be equated to a lack of intelligence, but rather, to a lack of ability to hear and a lack of experience in the types of situations that normal children and adults encounter (Furth, 1966; Vernon, 1969; Mindel & Vernon, 1971; Hoemann & Ullman, 1976). The same holds true for the hard of hearing. Like the deaf, psychological tests may be measuring the hard of hearing's language deficiency due to his impairment, not his actual mental capacity (Berg & Fletcher, 1970).

In addition, the deaf and hard of hearing are subjected to negative attitudes from their parents, who upon discovering that their child has a hearing impairment, may display feelings of shock, denial and rejection (Vernon, 1972; Stewart, 1973). Either way, parental attitudes may affect the psychological and social character of the hearing impaired individual. According to Mindel and Vernon (1971) "If the parent denies the deafness . . . the deaf child is then forced to see his deafness, and therefore himself, as reproachful--an object of guilt and low self-esteem" (p. 89).

This negative self-regard on the part of the deaf child will carry over into adult life unless these parent-child attitudes are identified and rectified where necessary.

Whether the onset of hearing loss is rapid or gradual, the effects

of hearing loss on the personality are of concern. However, the nature or degree of the auditory impairment is not as detrimental as the definition of the impairment. How one defines or labels a particular handicap will influence the handicapped person's intended and actual behavior (Rothschild, 1963).

In addition to defining a particular handicap, it is also necessary to look at how one regards the limitations of the handicap and what these limitations are. For example, in a study by Daniel and Alston (1972), professional rehabilitation personnel were required to rate how a profoundly deaf individual would function in the vocational, social and educational areas of life. Nine different handicaps were employed in this study, but for the purpose of this review, only the results pertaining to the deaf handicap will be discussed. The results indicated that:

> Vocational rehabilitation counselors and supervisors apparently feel that a profoundly deaf individual faces a relatively severe handicap in the educational and social areas of functioning . . . the vocational area of functioning was viewed as presently a relatively less severe handicap. (p. 51)

Contrary to the evidence just presented, one would assume that if a deaf individual encounters limitations and hardships within the educational and social areas of life, the vocational opportunities available to him would be greatly affected. Vocational functioning is a crucial issue in light of the massive underemployment and unemployment faced by the deaf (Vernon, 1969; Sussman & Stewart, 1971; Vernon, 1975).

The attitude of potential employers is of vital concern to rehabilitation. Although a generalized attitude of indifference is held toward the deaf, they encounter much discrimination in the occupational

field. Due to the deaf's communicative and educational limitations, vocational opportunities become scarce.

According to Sussman and Stewart (1971) "Everywhere we find deaf men and women of normal or above abilities operating automatic machines, performing simple assembly line operations, or otherwise occupied in unchallenging routines" (p. 25). This may be due to the employer's lack of knowledge of the deaf's potential, and lack of training facilities available to the deaf.

Vernon's (1971) survey of occupational opportunities available to the deaf offers a more realistic picture of the employment situation. He concludes that:

> . . . eighty-seven percent of deaf people are employed in manual labour, as contrasted to less than fifty percent of the general population. Only seventeen percent of the deaf are white collar workers as compared to forty-six percent of the general population. (Sussman & Stewart, 1971, p. 102)

If the deaf individual also happens to be Black, he will encounter even more discrimination.

Although more research is needed in reviewing the employer's attitude toward the deaf, one study can be included here. A study conducted by Rickard, Triandis and Patterson (1963) asked samples of personnel directors and school administrators to make judgments as to whether they would recommend hiring or not hiring several classes of disabled persons as an accountant or third grade teacher. The following classes of disability were employed: deaf, confined to wheelchair, epileptic, former psychiatric patient, ex-prisoner, tuberculosis patient, and non-disabled. Greatest prejudice was shown toward the epileptic, ex-prisoner and for-

mer psychiatric patient; prejudice toward the deaf was displayed when recommendations were made regarding the third grade teacher role.

In addition, employee reaction toward the handicapped is also felt to influence the vocational rehabilitation of this minority group. Arnholter (1963) and DeLevie (1966) both concluded from their investigations that the disabled were not entirely accepted. However, according to DeLevie (1966), the disabled were more acceptable as co-workers than as friends.

Research investigations concerning employer's and employee's attitude toward the hard of hearing could not be found. Lack of research in this area may be due to the invisibility of the hard of hearing's handicap. Job opportunities are not as restricted as they are for the deaf, but it would be interesting to find out what types of occupations the hard of hearing do hold, what types of occupations they tend to avoid, and how they interact with other fellow employees.

In terms of general attitudes toward the hearing impaired, it becomes necessary to realize that how society regards the deaf or hard of hearing, will influence their own perceptions of themselves (Eiseman, 1972). Hearing losses affect individuals in various ways and each individual's reaction is different. According to Griffith (1974):

> Some hard of hearing individuals are extroverts, who have developed a positive attitude about themselves and their disability, while others are introverts, who have permitted their hearing disability to master them, instead of them mastering the disability. (p. 2)

If the latter predominates, the resulting feelings of insecurity, defeatism, lack of social contacts and lack of self-confidence will interfere with the counseling process.

However, these feelings of insecurity, lack of self-confidence or whatever, are the whole purpose for the hearing impaired individual seeking counseling in the first place. The goal of counseling is to prepare the client to become an independent, mature decision-maker, able to deal competently with everyday problems (Bolton, 1976). If this is true, it is important for the counselor to reflect upon his own attitudes toward the handicapped individual, since his attitudes will influence the success of the counseling process.

Counselor's Attitude Toward Handicapped Individuals in General

Since counseling is a relationship in which the attitudes of the counselor are expressed (Sussman & Stewart, 1971), it becomes necessary to realize what types of attitudes counselors hold toward handicapped individuals. Although research in this area is rather limited with regard to the hearing impaired, there are some studies worth mentioning.

The rehabilitation literature indicates that the disabled are often perceived in a prejudicial, negative manner by the able bodied, which includes counselors as well as the general public (Gellman, 1959; Mallenby, 1975). This may be due to the fact that our society places a strong emphasis on good looks and on fitting in with the group. Therefore, the person who deviates from these qualifications may be regarded as notably different and subjected to prejudice (Eiseman, 1972). Although hearing impairment is not a noticable handicap, once the disability is known to exist, prejudice and negative attitudes may intervene.

There is a tendency to regard any handicapped individual as being

'different' from the normal. Bell (1962) supports this statement, maintaining that the nondisabled may be accepting of the handicapping conditions, yet still regard the disabled or handicapped individuals as "different" from the general population. Furthermore, Bell (1962) contends that ". . . to function as an efficient and successful therapist with the disabled, one must accept the view that the disabled are, to a certain extent, different from the physically normal" (p. 185). Reality does cause the nondisabled, the therapist or the general public to regard the disabled as being different from the normal. However, when this attitude of 'difference' prevails, the handicapped individual may be treated in a manner not similar to normal individuals. This attitude may be due to the lack of knowledge and lack of contact with various types of handicapped persons.

DuBrow (1965) and Mallenby (1975) maintain that if a handicapped and a normal person were given the opportunity to become acquainted with one another, perhaps prejudice and lack of understanding might be reduced. Extended contacts with the disabled for example, has led Yuker (1965) and Yuker, Block and Young (1966) to conclude that attitude change is possible.

There are other studies concerning the 'contact' factor with the disabled that are worth mentioning here. Gaier, Linkowski and Jacques (1968) concluded from their study that the effect of contact with the mentally and physically disabled produced favourable perceptions of disability.

Palmerton and Frumkin (1969c, 1969d) conducted two studies, looking at the contact variable. In one study, they hypothesized that ". . .

increased frequency of contact with disabled persons would lead to more intense attitudes regardless of whether the attitude was favorable or unfavorable" (p. 434). The findings indicated that college counselors possessing a low frequency of contact with disabled persons had considerably less intense attitudes toward disabled persons than did counselors with a high frequency of contact. Palmerton and Frumkin (1969c) believed that the amount of contact with disabled persons may determine the intensity of counselor's attitude towards them. It would seem that the more contact a counselor had with the disabled, the more adequate and experienced he would become in counseling the disabled and, therefore, if he felt positive about his counseling capabilities toward the disabled, he would feel positive in his attitude toward the disabled (MacDaniel, 1969).

Goldin (1966) and Brickey (1969) looked at the competency variable of rehabilitation counselors towards various disabilities. The studies indicated that rehabilitation counselors do feel more competent in working with some disabilities than others, and the Brickey (1969) study illustrated which disabilities the counselors felt more competent in working with. On general ability to work with certain disabilities, the counselors ranked their competence with certain disabilities in the following manner: amputation, orthopedic, cardiac, back disability, retardation, epilepsy, psychiatric, public offender, cerebral palsy, brain damage, visual, alcoholism, and speech or hearing.

From the above information, one can conclude that rehabilitation counselors would feel least competent in dealing with hearing impaired cases, and as Brickey (1969) concluded, the counselors felt more specialization was needed in this area. According to Goldin's study (1966),

the reason for the least case preference for speech and hearing was lack of speed and ease of success in achieving vocational rehabilitation.

Palmerton and Frumkin (1969d) believed that the 'type' of contact between the counselor and the physically disabled was another important factor to consider. They found that counselors who displayed high enjoyment of contact with the physically disabled had favorable attitudes towards them. Counselors who tended to avoid contact with the disabled, usually possessed unfavorable attitudes.

A study conducted by Higgs (1971), employing different groups of subjects (four secondary school groups, two groups of college undergraduates and four groups of counselors and parents) found that high school subjects possessed lower contact ratings, lower levels of knowledge, and less positive attitudes toward physically disabled persons than other groups. This finding may be due to high school students' lack of exposure to new situations, lack of experience with the disabled, as opposed to a counselor, who may encounter a few disabled individuals in the counseling setting. This finding coincides with Yuker, Block and Young's study (1966), which concluded that acceptance of physical disability increased with formal education.

The final study to be considered dealing with the 'contact' aspect, was conducted by Genskow and Maglione (1965). They investigated familiarity with disability and expressed attitudes of college students toward the disabled. An interesting variation was introduced in having questionnaires administered to each group by two different individuals--an able bodied person and a person in a wheelchair. Subjects for this study were 111 college students in four classes at two state universities, one which had an active and extensive handicapped student program and

the other none. Once again, it was found that familiarity with the physically disabled, through direct or indirect contacts, led to a more positive attitude.

From the above studies it can be seen that extended contacts with the handicapped influence one's attitude towards them. Through these contacts, we learn to see a handicapped individual as a person with a disability, and not as a 'disabled person'.

Vernon (1967) advocates that one of the primary responsibilities of the counselor is to be aware of the misconceptions held about deafness and other handicaps and to educate the public, especially the potential employers and associates of deaf clients. The more knowledgable one becomes about a particular handicap, its etiology, its limitations, the more understanding one becomes toward the handicapped individual. As Krauft, Rubin, Cook and Bozarth (1971) concluded from their study, "Counselors with more experience and education held more favorable attitudes toward the disabled in general than did counselors with less experience and education" (p. 53). With this deeper understanding, it is hoped that by regarding the handicapped individual as first a human being, his handicap becomes secondary.

However, studies by Downes (1967), Palmerton and Frumkin (1969b), Kennedy and Anthony (1972) and Galloway (1973) provide evidence contrary to the Krauft et al. study (1971). Palmerton and Frumkin (1969b) concluded that the greater the amount of knowledge the counselor possessed about the physically disabled, the more unfavorable the attitudes were toward the disabled. Downes (1967) and Galloway (1973) both concluded from their studies, that there was no relationship between the amount of

education that the rehabilitation counselor had and their attitudes toward deafness and deaf persons. Kennedy and Anthony (1972) further concluded that ". . . rehabilitation counselors behave no differently than other counselors who have received no specialized training in dealing with physically disabled individuals" (p. 33). Therefore, it is necessary for the counselor to be aware of his feelings toward the handicapped, and where it is possible, make referrals or transfers to another professional if he feels the counseling relationship will be jeopardized.

Looking at counselor attitudes more closely, one can refer back to the study by Krauft, Rubin, Cook and Bozarth (1971). In this study, counselors ranked eight disabilities from most to least favorable. Deafness ranked fifth. This study coincides with three separate rank-order studies (Janicki, 1970; Wilson, Sakata & Frumkin, 1968; Wilson, Beatty & Frumkin, 1967), whereby health professional and rehabilitation counseling students ranked sensory disabilities (blindness and deafness) as significantly more disturbing if so afflicted than disabilities affecting the rest of the body such as amputations and tuberculosis. Psychogenic disorders were not included in these studies.

Significant differences have also been found between males and females in their rank ordering of specific disabilities as such disabilities might be disturing to them (Frumkin, Sakata & Wilson, 1970; Wilson, Beatty & Frumkin, 1967). In these studies with health professionals and rehabilitation counseling students, men consistently perceived deafness as being more disturbing to them if so afflicted, and women consistently perceived the disabilities of arm amputation and arthritis to be more disturbing. Frumkin, Sakata and Wilson (1970) maintain that

attitudes of males and females preparing for a career in rehabilitation counseling may centre around matters of sexual identification and beauty more than practical considerations concerned with potential adjustment problems of persons with such handicaps.

Differential attitudes toward acceptance of disability also prevails among males and females. DeLevie (1966) and Yuker, Block and Young (1966) concluded from their studies that females are more accepting and hold more positive attitudes toward the disabled than males. However, studies by Bell (1962) and Siller and Chipman (1965) found no significant differences between males and females in their attitudes toward the disabled.

An auditory impairment may be considered less favorable in some instances, due to the limitations imposed by deaf and the counselors in terms of communication. The inability of the counselor to communicate to the deaf in sign language, for example, may prolong the counseling process or leave problems unresolved.

Therefore, from the studies presented here, one can assume that hearing impairment, as a disability, is not perceived too favorably by counselors or the general public. However, Jordon and Friesen (1968) found that positive attitudes toward the disabled were more characteristic of modern countries such as the United States, than more traditional societies, such as Columbia and Peru.

The invisibility of the handicap may be one of the reasons for unfavorable attitudes, since it may present a misleading picture about the person and the problem he encounters (Semple, 1970; Yates, 1973). One may hold high expectations of the (deaf) person, because he looks like

anyone else and, therefore, is expected to act like anyone else. For example, one may expect the person who is deaf to communicate or carry on a conversation, only to discover that he cannot. Persons with mild disabilities suffer greater frustration and maladjustment than the severely disabled because social expectations are more strenuous for them and yet they may not be able to perform (MacDaniel, 1969). A person with a mild disability, because he is almost normal, may have a greater desire to hide and deny his handicap, thereby prolonging his adjustment to his handicap and acceptance of himself (Wright, 1960). Therefore, the underlying problems of a handicap must be thoroughly understood by the counselor, in order that the client may receive the maximum benefits of the counseling process.

Handicap's Attitude and Preference of Counselors (Normal and Handicapped)

Since the counseling relationship involves both the client and the counselor, the client's attitude toward the counselor (normal or handicapped) could influence the success of the counseling process.

The effect of an obvious physical disability of a counselor upon the initial preferences and pre-counseling expectations of the clients was investigated by Brabham (1969), Brabham and Thoreson (1973), J. Mitchell (1975) and D. Mitchell and Frederickson (1975). Differences were found in the frequency with which the counselor in the wheelchair, the counselor with crutches, the blind counselor, and the counselor with no disability were selected. Disabled subjects tended to attribute greater credibility to a disabled counselor; able bodies subjects also attributed higher credibility to a disabled counselor who "had made it"

despite the limitations imposed by a physical disability.

One conclusion we can draw from the above findings is that the disabled person prefers a disabled counselor, and that the able bodied person does not necessarily prefer the able bodied counselor. However, able bodied subjects tended to choose the disabled counselor when the problems pertained to vocational or educational issues (Mitchell and Frederickson, 1975). Handicapped individuals prefer handicapped counselors because the latter would be in a better position to understand the limitations of a handicap, and would probably empathize with the client on a higher level. This coincides with the findings of Mitchell and Allen (1973), who reported that:

> The disabled counselor was perceived as being more aware and actively reaching out to the client, as holding the client in a more positive regard, as offering this regard in a nonconditional manner, and as being more genuine and congruent. (p. 72)

Studies relating to the hearing impaired individual's preference for counselors (deaf or hard of hearing) are very few in number. According to Pettingill's (1968) experience in counseling the deaf, he maintains that "To be able to adequately judge a deaf person's ability or disability requires the deep empathy that only deafness itself can give" (p. 12). However, some deaf individuals, having some negative attitudes toward their own handicap, may view the deaf counselor as "inferior and less worthy, and that a deaf counselor cannot be of help" (Sussman & Stewart, 1971, p. 75). In addition, because the deaf counselor may seek the deaf community for much of his social needs, there are some deaf clients who may question the deaf counselor's ability to keep their interviews confidential (Sussman & Stewart, 1971). Therefore, when the

need arises, although the deaf counselor may be in a better position to empathize with the deaf individual, the counselor may have to prove his competence and uphold the issue of confidentiality, before some deaf individuals will trust him enough to share their problems with him.

In other instances, if the auditory impairment is not as severe as total deafness, the handicap's preference may be different. For example, according to Rosen's (1968) findings, "Of the 107 subjects . . . 1 in 5 made a clear choice for a deaf counselor. The remaining 80 percent preferred a hearing counselor . . ." (p. 21). Students with least severe deafness and poorer ability to communicate by the language of signs showed greatest preference for hearing counselors.

Riekehof (1971) found similar results, although she was looking at preferences of deaf college students toward a deaf or hearing clergyman. One of the reasons for the deaf's preference for the hearing counselor may be that the hearing counselor has more outside contacts, can make telephone calls, can communicate with people outside the deaf world and has knowledge of the dominant culture. In the counseling situation, the above attributes are important if the counselor and client are dealing with problems not related to the hearing impairment itself. Furthermore, the deaf have no conception of a preferred deaf counselor, since deaf, well-trained counselors are rare (Rosen, 1968). This may also account for their hearing counselor preference.

No direct information could be found pertaining to studies about the hard of hearing's preferences. The researcher can only assume that if the individual has problems related in some way with his handicap, he would be more inclined to choose a hard of hearing counselor rather

than a hearing counselor.

Commonality Concept

'Comonality,' as defined by Webster's New Collegiate Dictionary, means the possession of common features or attributes. Concerning this study, a commonality of problems between the counselor and the client may generate a more effective counseling process, aspiring empathy, genuine understanding and sincerity on the part of the counselor and provide the client with a feeling that he is "not alone" in facing the limitations of his handicap.

According to Stefflre and Leafgren (1964), ". . . a similarity between persons, or at least felt similarity, does seem to bear some relationship to the ability to understand the other person" (p. 459). 'Similarity between persons' for Stefflre and Leafgren (1964) pertained to personality characteristics such as intelligence, or socio-economic status. They did not include handicap characteristics. The present study assumes that similarity in handicaps between client and counselor will yield a more genuine relationship.

Similarity in handicaps between the client and the counselor is best understood with an example. According to Russell (1949), an occupational therapist with a hook prothesis can teach arm amputees a good deal more than the mechanical use of prothetic devices. He states:

> . . . sure, it was easy for her (an able bodied occupational therapist) to show me how to turn on a water faucet or drop a coin in a box. All you did was thus and so, and then they'd demonstrate for me. That didn't mean much to me. Of course, they could do it themselves. They had hands. But if someone with hooks had demonstrated how to open a window or turn on a faucet not with hands, but with hooks, he would have made a deep and lasting impression on me. (p. 104-105)

Reflecting upon the feelings of a recent quadriplegic, Tim Caywood (1974) describes some of his experiences with his disability in the following manner:

> For the first time I saw disabilities to which I had previously never given any thought. I also saw people who had the same injury as I did, which, in a strange way made me feel better. I no longer felt like I was the only one going through this. (p. 23)

In addition, a paraplegic counselor felt the commonality aspect of the disability greatly affects the counseling process and its outcome. Seybold (1974) reveals that:

> Perhaps being a paraplegic myself, I have an easier time establishing rapport with my spinal cord injured clients. They don't have to feel embarrassed about awkward questions and explanations because they know I know exactly what they are experiencing. (p. 11)

The above quote reflects the major thrust of the present study. Does a hard of hearing individual "feel better" talking to a hard of hearing counselor about his problems? The commonality element would provide the client with the assurance of knowing that the counselor really understands what his client is experiencing and what problems he may encounter in the future. Naturally, since we are all unique, no two individuals derive the same experience from a particular situation. However, the hard of hearing counselor may be in a better position to understand the limitations imposed by the handicap and give the client the proper guidance and encouragement to face up to his limitations and work from there.

Similar types of experiences have been found in programs for alcoholic and drug addicted individuals. In both programs, ex-alcoholics and ex-addicts have been employed as counselors with successful out-

comes (Chalfant, 1974).

The experiential knowledge of the ex-addict or ex-alcoholic has proven useful in helping other addicts and alcoholics overcome their addictive habits. According to one ex-addict counselor:

> . . . you are the link between the patient and the program . . . This link implies to the patient that you have become that which he is striving to become and that you may be his one hope of accomplishment. (Trader, 1975, p. 142)

In addition, Snowden and Cotler (1974) have reported the following conclusions about the ex-addict counselor:

> Counselor openness to various aspects of their own distress, including doubts over adequacy and concern with physiological well being, could facilitate counseling in several ways. These concerns presumably parallel those of clients. A counselor who acknowledges and discusses such problems might more convincingly communicate empathic understanding in his counseling relationships, and his efforts would have access to the process of client identification and modeling. (p. 337)

A study by Neher and Dicken (1975) investigated client-counselor problem similarity and counselor empathy. Trouble with grades was selected as the problem which the counselor and client might have in common. One of the results confirmed the findings stated in the previous studies mentioned. When grade problem was considered the common element between client and counselor, this "perceived bond of common experience could result in a compensating increase of attention, effort and empathy" (p. 364). It would have been interesting to see what the findings would have been if hearing impairment was the common element.

From the above studies, it can be concluded that the commonality element bears some significant functions, especially in the effectiveness of the counselor in the therapeutic process. Indirectly, coun-

selor effectiveness will influence the progress and well-being of the client being served.

Summary

A search of the literature on general attitudes toward the hearing impaired, counselor's attitude toward the handicapped in general, the handicap's attitude and preference of counselors (normal and hancicapped), and the commonality concept, supports the importance of investigating the problem of this study. Based on the literature presented, one can see that the auditory impairment, especially the hard of hearing category, has been given little recognition in terms of counseling. Although there has been some indication that counseling services are needed for the deaf and hard of hearing (Boesen, 1975), we are still a long way off from attaining that goal. Public education of the auditory handicap must be achieved (DuBrow, 1965; DeLevie, 1966; Conine, 1968; Vernon, 1971; Boesen, 1975), before any adequate service can be provided for the hearing impaired.

There are still many questions which remain unanswered. What is the basis of successful counseling between the hard of hearing and the deaf? Would the deaf prefer a hard of hearing counselor over a hearing counselor in a counseling situation, if both counselors were equally qualified in communicative functions (sign language, fingerspelling, lipreading) for the deaf? How can attitudes toward the deaf and hard of hearing be further explored and modified? What types of problems would the hard of hearing client and the hard of hearing counselor have in common, besides the auditory impairment?

In the final analysis, we need to know more about the hard of hearing and their needs in the counseling situation. Without this knowledge, we will never know whether the hard of hearing are adequately served within the counseling process, and in everyday living.

CHAPTER III

METHODOLOGY

Subjects and Setting

The sample in this investigation consisted of individuals with some degree of hearing impairment, in one or both ears. There were 22 subjects who could be classified as hard of hearing (impairment in both ears). The remaining 9 subjects were individuals who suffered a hearing loss in one ear only.

The sample was drawn from the Audiology Department at the Glenrose Hospital. In total, 31 subjects participated in this study. Twenty-six subjects responded to the original questionnaire and five more to the follow-up letter. Thus, 31 of a possible 44 subjects responded for a 70 percent return rate.

Fifteen respondents were male; sixteen were female. Average age was 42.29 with a range of 17-59, and a standard deviation of 12.59. Table 1 shows a breakdown of means and standard deviations according to age for males, females and total. Educational and vocational background varied for each individual.

Instruments

Since there are no known instruments for measuring the hard of hearing's preference for a hard of hearing counselor or hearing counselor, a new instrument, in the form of a questionnaire was constructed (see Appendix A, p. 64). The questionnaire was designed using three major sources. General questionnaire design procedure followed suggestions of Oppenheim (1966); questions relating to demographic data and coun-

selor preferences were based on a study by Riekehof (1971); and questions pertaining to counseling facilities were incorporated from Bosen's (1975) findings.

The first eleven questions of the questionnaire pertain to case history or background information of the individual. The remaining questions require that the subjects reveal their experiences within the counseling situation, their stated counselor preference, the reason for their particular choice, and their selection of problems they would most likely and least likely wish to discuss with a counselor. Analysis of the subject's responses were based on hypotheses outlined in Chapter I.

Table 1

Means and Standard Deviations

According to Age

Age	Means	Standard Deviations
Males	43.00	10.32
Females	41.63	14.71
Total	42.29	12.59

Procedure

Potential subjects from the Glenrose Hospital were given a letter explaining the purpose of the study and those who agreed to participate in the study signed release forms giving the experimenter access to their audiology reports (see Appendix B, p. 70). The letter and release form were given to the subjects after their audiological assessments

were completed.

Upon securing the client's signature on the appropriate release form, the audiologists at the Glenrose Hospital forwarded the following client information to the researcher: name, address, age, degree of hearing loss, and type of hearing loss. Appendix C contains the form upon which the audiologists submitted the information. Once the information was received by the researcher, the appropriate cover letter, questionnaire, and stamped self-addressed envelope were mailed to the potential subject. Follow-up letters were sent to subjects who did not return the questionnaire within two weeks of the day the questionnaire was sent to them. (Refer to Appendix D, p. 74, for a sample of the follow-up letter).

Data Analysis

Chi square (Freeman, 1965) was chosen to test the major hypothesis of this study: (a) Hard of hearing individuals prefer a hard of hearing counselor to a hearing counselor. Chi square (Freeman, 1965), using Yates' correction for 1 degree of freedom, was selected to test the following two hypotheses: (b) Hard of hearing females show a greater preference for the hard of hearing counselor than hard of hearing males, and (c) Hard of hearing individuals with hearing losses in both ears show a greater preference for the hard of hearing counselor than hard of hearing individuals with a hearing loss in one ear.

The coefficient of differentiation (Freeman, 1965) was selected to measure an association between counselor preference and the degree of hearing loss in hypothesis four. Hypothesis four contends that: (d) The greater the degree of hearing loss, the greater the hard of hearing's

preference for a hard of hearing counselor.

A correlated t-test (Ferguson, 1966) was employed to test the remaining hypothesis: (e) Hard of hearing individuals show a greater preference for the hard of hearing counselor when the relationship involves discussing the handicap itself, problems with the self, home and social types of problems and less preference when the discussion involves problems relating to educational, vocational and moral matters.

In order to apply the appropriate statistical techniques, all experimental hypotheses were tested in null form. The .05 level of probability was accepted for rejection of each null hypothesis.

CHAPTER IV

RESULTS

Hypothesis I

The major experimental hypothesis stated that: hard of hearing individuals prefer a hard of hearing counselor to a hearing counselor. A .05 level of significance was adopted for rejection of the null hypothesis.

An analysis of chi square, with two degree of freedom, yielded a value of 12.46, which was significant at the .01 level. Therefore, the major experimental hypothesis was supported.

Hypothesis II

The second experimental hypothesis stated that: hard of hearing females show a greater preference for the hard of hearing counselor than hard of hearing males. A .05 level of significance was adopted for rejection of the null hypothesis.

A two-way classification of chi square, using Yates' correction for one degree of freedom, yielded a value of .38, which was not significant at the .05 level. Table 2 shows the distribution of counselor preference according to sex of the subjects. Therefore, the second experimental hypothesis was not supported.

Hypothesis III

The third experimental hypothesis stated that: hard of hearing individuals with hearing losses in both ears show a greater preference for the hard of hearing counselor than hard of hearing individuals with hearing losses in only one ear. A .05 level of significance was

adopted for rejection of the null hypothesis.

Table 2

Distribution of Counselor Preference

According to Sex of Subjects

Counselor Preference	Male N	Male %	Female N	Female %	Total N	Total %
Hard of Hearing	10	66.66	8	50.00	18	58.06
Hearing	4	26.66	7	43.75	11	35.48
None*	1	6.66	1	6.25	2	6.45
Total	15	99.98	16	100.00	31	99.99
	X^2= .38 n.s. 1 d.f.					

* 2 subjects did not state a counselor preference and were excluded from the statistical analysis.

A two-way classification of chi square, using Yate's correction for one degree of freedom, yielded a value of .20, which was not significant at the .05 level. Table 3 illustrates the distribution of counselor preference according to 'both ears' and 'one ear' hearing loss. Therefore, the second experimental hypothesis was not supported.

Hypothesis IV

The fourth experimental hypothesis stated that: the greater the degree of hearing loss, the greater the hard of hearing's preference for a hard of hearing counselor. To determine the degree of association be-

tween counselor preference and degree of hearing loss, the coefficient of differentiation (θ) was computed.

The coefficient of differentiation was .0105, indicating that there is almost no association between counselor preference and degree of hearing loss. Therefore, Hypothesis IV was not supported.

Table 3

Distribution of Counselor Preference

According to Both Ears and

One Ear Hearing Loss

Counselor Preference	Both Ears N	%	One Ear N	%	Total N	%
Hard of Hearing	12	54.54	6	66.66	18	58.06
Hearing	9	40.90	2	22.22	11	35.48
None*	1	4.54	1	11.11	2	6.45
Total	22	99.98	9	99.99	31	99.99
	X^2 = .20 n.s.		1 d.f.			

* 2 subjects did not state a counselor preference and were excluded from the statistical analysis.

Hypothesis V

The fifth experimental hypothesis stated that: hard of hearing individuals show greater preference for a hard of hearing counselor when the relationship involves discussing the handicap itself; i.e., problems with the self, home and social types of problems and less pre-

ference when the discussion involves problems relating to educational, vocational and moral matters. A .05 level of significance was adopted for rejection of the null hypothesis.

Table 4

Distribution of Scores of 'Most Preferred' and 'Least Preferred' Problems of Subjects Stating a Preference for a Hard of Hearing Counselor

Subjects	Most Preferred	Least Preferred
1	1.2	1.33
2	1.2	.66
3	1.0	2.0
4	.8	1.66
5	1.2	1.0
6	.8	0
7	1.0	.66
8	.8	1.66
9	1.2	0
10	1.2	1.33
11	.8	1.0
12	.8	0
13	1.0	1.33
14	1.2	2.0
15	.2	0
16	1.2	1.66
17	.2	1.0
18	.6	1.33

A t-test for correlated groups was performed on the data provided in Table 4. The observed value of t (-.78) was well below $.05^{t}(17)$ of 2.110, and therefore, the difference between means was not significant. Hypothesis V was not supported.

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

This study was intended to be a description and exploratory investigation of the hard of hearing's counselor preference and factors relating to the counselor preference.

The sample consisted of 31 individuals with some degree of hearing impairment (in one or both ears), drawn from the Audiology Department at the Glenrose Hospital, in Edmonton, Alberta.

The first hypothesis, the major experimental hypothesis of this study, was found to be significant at the .01 level of significance and was therefore accepted. The remaining four experimental hypotheses of this study were not supported. On the basis of the sample obtained, the following conclusions were derived.

1. Hard of hearing individuals did make a clear preference for a hard of hearing counselor as opposed to a hearing counselor to discuss their problems.

2. Hard of hearing females did not show a greater preference for a hard of hearing counselor than hard of hearing males.

3. Individuals with hearing losses in both ears did not show a greater preference for a hard of hearing counselor than hard of hearing individuals with hearing losses in one ear only. When the two groups (both ears and one ear hearing loss) were combined, 18 or 58.06 percent of the 31 respondents indicated a preference for the hard of hearing counselor.

4. No association was obtained between the hard of hearing's counselor preference and the degree of hearing loss endured by the hard of hearing subjects.

5. Of the 18 respondents who stated a preference for the hard of hearing counselor, no definite conclusions can be made pertaining to the types of problems (hearing handicap, self, home, social, educational, vocational, and moral) these respondents would 'most prefer' and 'least prefer' to discuss with a hard of hearing counselor.

6. Of the 31 respondents, 26 or 83 percent made incorrect estimations of their hearing loss, suggesting that misinformation, misunderstanding or lack of information prevails between the audiologist and the individual whose hearing is being evaluated.

7. The majority of subjects in this study were unfamiliar with any counseling services available to meet their immediate needs.

8. Eighteen respondents who stated a hard of hearing counselor preference, based their choice on the commonality of problems between themselves and the counselor. They believed there would be a deeper understanding between the respondent and the counselor with regards to the hearing impairment. The remaining 11 subjects chose the hearing counselor because they felt their hearing loss to be so slight that it would not interfere with the counseling situation or everyday living.

Discussion

This study showed that hard of hearing individuals do prefer a hard of hearing counselor to a hearing counselor. Of the 31 respondents who participated in this study, 18 or 58.06 percent stated a preference for

a hard of hearing counselor; 11 or 35.47 percent stated a hearing counselor preference; and two or 6.45 percent stated no counselor preference at all.

Specifically, in terms of the five experimental hypotheses outlined in this study, only one of the hypotheses found support at the .05 level of significance. Hard of hearing individuals did state a clear preference for a hard of hearing counselor, suggesting that the commonality of problems existing between the two individuals is an important factor. This finding corresponds with other studies (Chalfant, 1974; Snowden & Cotler, 1974; Neher & Dicken, 1975; Trader, 1975), whereby it was found that when a common element exists between the client and the counselor, this "perceived bond of common experience could result in a compensating increase of attention, effort and empathy" (Neher & Dicken, 1975, p. 364).

However, the remaining four experimental hypotheses outlined in this study were not supported at the .05 level of significance. Firstly, hard of hearing females did not show a greater preference for the hard of hearing counselor as opposed to hard of hearing males. This finding does not correspond with the few studies in relation to the female's attitude toward hearing impaired individuals or other handicapped groups. However, the studies reviewed (Frumkin, Sakata & Wilson, 1970; Yuker, Block & Young, 1966; DeLevie, 1966) looked at attitudes of females who were not disabled in any way.

The present study offers an added dimension to the issue of male and female attitudes toward the handicapped: the hard of hearing's attitude and preference for a counselor having a similar handicap. Therefore, based on the lack of previous research and the small sample in the

present study, it appears that hard of hearing females do not indicate a greater preference for a hard of hearing counselor than do hard of hearing males.

Secondly, individuals with hearing losses in both ears did not show a greater preference for a hard of hearing counselor than hard of hearing individuals with hearing losses in one ear only. Nevertheless, when the two groups (both ear and one ear hearing loss) are combined, 18 or 58.06 percent of the 31 respondents indicated a preference for the hard of hearing counselor.

Thirdly, no association was found between counselor preference and degree of hearing loss. However, the small sample size may have contributed to this finding. More respondents with hearing losses in the mild, moderate, severe and profound categories are needed in order to effectively determine the degree of association between counselor preference and degree of hearing loss.

The majority of the subjects in the present study fell within the normal and slight hearing range. In other words, when looking at the degree of hearing loss in the better ear, 22 or 75.86 percent of the 29 respondents fell within the normal and slight hearing range. This left only 7 or 24.14 percent of the respondents to cover the remaining four hearing loss categories, which is not a sufficient number. Table 5 shows the frequency distribution of counselor preference in relation to degree of hearing loss.

Fourthly, of the 18 respondents who stated a preference for the hard of hearing counselor, no definite conclusions can be made pertaining to the types of problems these respondents would 'most prefer' and 'least

prefer' to discuss with a hard of hearing counselor. This may be a result of individual differences, and different types of problems encountered by each individual.

Table 5

Frequency Distribution of Counselor Preference in Relation to Degree of Hearing Loss

Degree of Hearing Loss	Counselor Preference	
	Hard of Hearing	Hearing
Normal	6	2
Slight	8	6
Mild	2	2
Moderate	2	0
Severe	0	0
Profound	1	0

This same finding exists when all 29 respondents are included. Two subjects did not feel they had any of the problems listed (see Appendix A, p. 67) that would warrant discussion with a counselor. Regardless of counselor preference, there was no definite or common type of problem that the subjects wished to discuss with a counselor.

Other Findings

An interesting finding was noted with regards to the respondent's perception of his hearing loss. Pertaining to questions six and seven

of the questionnaire (see Appendix A, p. 64), there was an incongruency between the audiologist's report of the respondent's hearing loss and the respondent's estimation of his/her hearing loss. In 24 or 77.41 percent of the cases, the respondents perceived their hearing loss to be more severe than it actually was. For example, if an individual had a slight hearing loss according to the audiologist's report, the respondent reported a moderate loss. Five or 16.12 percent of the respondents perceived their hearing loss in both ears correctly. One respondent did not know the degree of hearing loss for the left ear. One individual indicated a hearing loss of less severity than it actually was--slight instead of a mild loss.

The above findings seem to suggest that audiologists have to spend more time and care in outlining the individual's hearing loss, in one or both ears. Of the 31 respondents, 26 or 83.87 percent made incorrect estimations of their hearing loss, suggesting that misinformation, misunderstanding or lack of information prevails. Professional care has to be undertaken by the audiologist in order that the hearing impaired individual perceives his hearing loss correctly and understands where he stands in relation to the entire hearing loss spectrum.

When looking at counseling facilities in general (refer to page 2 of questionnaire, Appendix A, p. 65), 27 of 31 respondents were unfamiliar with any counseling services available to meet their immediate needs. This corresponds with the findings of a survey (Boesen, 1975) conducted by the Alberta Co-ordinating Council on Deafness, which looked into the needs of hearing impaired people in the Greater Edmonton Region. According to this survey (1975), the hard of hearing sample listed counseling

and information services as their highest priority of services required.

Two respondents in this study considered the Audiology Department, at the Glenrose Hospital, as providing a counseling service with regards to hearing problems and technical difficulties with hearing aids. Two other respondents listed the following counseling services that they were familiar with: school, "Department of Mental Health Development," Family Counseling Services, Department of Social Services and the church clergyman.

With the existing breakdown, 27 (87.09 percent) of the hard of hearing subjects in this study did not know where to seek counseling assistance when necessary. More information must be provided for the hard of hearing about what counseling services are available to them.

Limitations of the Study

This study was intended to be a descriptive and exploratory investigation of the hard of hearing's counselor preference, and factors relating to the counselor preferences.

Although the majority of the hypotheses of this study were not supported, more specific and intensified studies are needed before definite conclusions can be reached about the need for counseling facilities for the hard of hearing, the necessity of recruiting hearing impaired individuals as counselors for the hearing impaired, and the hard of hearing's counselor preferences in the counseling situation.

Suggestions for Further Research

Further sampling and larger samples would be most helpful in determining how representative this sample is of hard of hearing individuals.

In addition, sampling both the hard of hearing and the deaf, may produce some interesting findings.

Further investigations might be made into the attitudes of hearing impaired individuals toward their hearing handicap in general, and more specifically, looking at the hard of hearing group and their perception of a hearing disability.

More research is needed to evaluate the necessity for training hearing impaired individuals in the counseling profession. In the present study, of the 18 respondents who stated a preference for the hard of hearing counselor, the predominant reason for their choice was the similarity of problems that may exist between the respondent and the counselor and thus, a deeper understanding on the part of the counselor about the client's hearing handicap and its limitations.

The remaining 11 respondents who chose the hearing counselor felt their hearing losses were so slight that it would not be a noticeable problem in the counseling situation and in everyday living.

Therefore, more specific research must be done looking at the preferences of individuals with hearing losses in the moderate, severe and profound categories and correlating them with counselor preference. Only when more intense investigations are conducted can an accurate statement be made about the need for hard of hearing counselors within the counseling realm.

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APPENDICES

APPENDIX A

Mrs. P. Gniazdowsky,
443 Michener Park,
Edmonton, Alberta.

Dear Sir or Madame:

The accompanying questionnaire deals with a study that I am conducting as a graduate student in Educational Psychology, University of Alberta. This study, under the supervision of Dr. J. Vargo, is required for the completion of my academic requirements in the Master's program.

The study is an attempt to look at some of the attitudes held by hard of hearing individuals toward counseling.

The success of this study depends upon the cooperation of people such as you. I would be grateful if you would assist me in this research by devoting ten minutes of your time to complete the enclosed questionnaire. I would also appreciate it if you could complete the questionnaire by _____, and mail it in the enclosed, self-addressed envelop.

Your name is not required since the information will not deal with individual cases. All information derived from the questionnaire will remain anonymous and will be used for statistical purposes only.

If there are any questions, please feel free to contact me at 435-5525, or my advisor, Dr. Jim Vargo, at 432-5989.

We look forward to hearing from you, and are most grateful for your help.

Yours sincerely,

(Mrs.) Patricia Gniazdowsky.

Attitude Questionnaire

To indicate your responses to the following questions, please check ( ) or fill in your answer within the brackets provided.

Sex: Male ( )
Female ( )

Age: 18-21 ( )
22-30 ( )
31-40 ( )
41-50 ( )
over 50 ( )

When did you first notice that you had a hearing problem?
Give your approximate age (_____)

How long have you had a hearing problem? (_____)

What type of loss do you have?

( ) a. sensori-neural (nerve damage)
( ) b. conductive
( ) c. mixed
( ) d. do not know
( ) e. other (please specify) _____

How severe would you say your hearing loss is, in your left ear?

( ) a. normal (0-25 db)
( ) b. slight (26-40 db)
( ) c. mild (41-55 db)
( ) d. moderate (56-70 db)
( ) e. severe (71-90 db)
( ) f. profound (over 90 db)
( ) g. do not know how severe my hearing loss is

How severe would you say your hearing loss is, in your right ear?

( ) a. normal (0-25 db)
( ) b. slight (26-40 db)

( ) c. mild (41-55 db)
( ) d. moderate (56-70 db)
( ) e. severe (71-90 db)
( ) f. profound (over 90 db)
( ) g. do not know how severe my hearing loss is

What do you think caused your hearing loss?

( ) a. illness (specify what type of illness _____)
( ) b. head injury
( ) c. drafts
( ) d. born with it
( ) e. do not know
( ) f. other (please specify) _____

How would you rate your speech and language development on a 1 to 10 scale? Mark an "x" on the scale below.

1	2	3	4	5	6	7	8	9	10
Very Poor		Poor		Average		Fair	Good		Very Good

What level of education have you achieved?

( ) a. up to Grade 8
( ) b. up to Grade 12
( ) c. Technical school, eg. NAIT
( ) d. College, eg. Alberta College
( ) e. University
( ) f. Other (please specify) _____

What is your present occupation?

Are you aware of any counseling services in your community, that would be capable of serving your needs? Yes ( )
No ( )

If you answered the above question "yes," which counselling services are you familiar with? List below in the space provided.

Have you every been to see a counselor to discuss a problem of any type?

Yes ( )

No ( )

If you have never seen a counselor, would you go and see one, if you needed to?

Yes ( )

No ( )

If you have answered "yes," when have you seen him or her last?

( ) a. six months ago

( ) b. within a year

( ) c. 1-5 years ago

( ) d. 5-10 years ago

( ) e. over ten years ago

How many times did you see the counselor concerning a particular problem?

( ) a. 1-4 times

( ) b. 4-8 times

( ) c. 8-12 times

( ) d. over 12 times

How long was one session, approximately?

( ) a. under 1/2 hour

( ) b. 1/2 - 1 hour

( ) c. 1 - 1 1/2 hours

( ) d. over 1 1/2 hours

If you had a choice between two counselors of equal training and experience, which one would you choose?

Hard of hearing counselor ( )

Hearing counselor ( )

In the above question, why did you choose the counselor that you did?

From the list below, which 3 problems would you prefer to discuss with a counselor?
Please list your three choices using 1, 2, and 3. 1 to indicate your first choice; 2 to indicate your second choice; and 3 to indicate your third choice.

( ) a. planning and outlining your educational future

( ) b. difficulty in expressing and/or controlling your feelings toward others

( ) c. family conflicts or pressures

( ) d. seeking to change something about yourself

( ) e. needing advice in making a decision that is right for you, even if it conflicts with other people's values and beliefs of what is right

( ) f. how to make more friends or have an active social life

( ) g. dissatisfied with present employment and seeking a new career

( ) h. hearing aid difficulties

( ) i. other (please specify) _____

From the list below, which problems would you least prefer to discuss with a counselor. Again, choose 3 problems and number them 1, 2, and 3, indicating the order of your choices.

( ) a. planning and outlining your educational future

( ) b. difficulty in expressing and/or controlling your feelings towards others

( ) c. family conflicts or pressures

( ) d. seeking to change something about yourself

( ) e. needing advice in making a decision that is right for you, even if it conflicts with other people's values and beliefs of what is right

( ) f. how to make more friends or have an active social life

( ) g. dissatisfied with present employment and seeking a new career

( ) h. hearing aid difficulties

( ) i. other (please specify) _____

APPENDIX B

Dear Sir or Madame:

You have been selected to participate in a survey, conducted by a University of Alberta student, working on her Master's degree. Patricia Gniazdowsky is doing an interesting study, looking into the needs of the hard of hearing, which could prove very useful to all of us.

However, before we can allow Patricia to contact you through the mail, we are seeking your permission to release your name and address, in order that Patricia may be able to contact you in the near future. Along with this, Patricia also requires information concerning the degree of your hearing loss, which we have on file. We would certainly hope that you will sign the necessary release form attached, in order to help Patricia out with her survey.

Please rest assured that any information we release to Patricia, with your permission, will be held in strict confidence.

If you have any questions concerning this request, feel free to get in touch with Patricia at 435-5525.

Special thanks are extended to you from Patricia, and we appreciate your cooperation and assistance. We hope you will comply with our request.

GLENROSE HOSPITAL

SPEECH PATHOLOGY - AUDIOLOGY DEPARTMENT

10230 - 111 Avenue, Edmonton, Alberta

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of relevant, confidential material regarding

_____ _____

(Name of Patient) (Hospital Number)

to Mrs. Patricia Gniazdowsky

(Name)

443 Michener Park, Edmonton, Alberta T6H 4M5

(Address)

_____ _____ _____

(Date) Witness Signature

_____

Relationship to patient

APPENDIX C

Information Required:

Name of Patient _____

Address of Patient _____

Age _____

Check off in the appropriate bracket space provided below.

Degree of Hearing Loss (Average of 500, 1000, 2000 Hz):

Degree of Loss (db)	Left Ear	Right Ear
Normal (0-25 db)	( )	( )
Slight (26-40 db)	( )	( )
Mild (41-55 db)	( )	( )
Moderate (56-70 db)	( )	( )
Severe (71-90 db)	( )	( )
Profound (over 90 db)	( )	( )

Type of Hearing Loss:

a. Conductive ( )

b. Sensori-neural ( )

c. Mixed ( )

d. Other (please specify _____) ( )

APPENDIX D

443 Michener Park,
Edmonton, Alberta.

Dear Sir or Madame:

Just a reminder! We would really appreciate it if you could fill out the questionnaire that we initially sent you.

The success of this study depends upon your cooperation. I would be grateful if you would assist me in this research by devoting ten minutes of your time to complete the questionnaire.

We look forward to hearing from you at your earliest convenience.

Thank you once again for your cooperation.

Yours sincerely,

(Mrs.) Patricia Gniazdowsky.